Health Statement

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

(Applicable to all 2-14 enrolling employees and non-guaranteed issue groups only)

If you would like to keep this statement confidential, please submit it in a sealed envelope along with your completed application.

Please complete the following health questionnaire. Your answers to the questions below do not affect your eligibility for coverage, and will not be used as a basis of excluding coverage for any medical condition, with the exception of a pre-existing condition if applicable to the terms of your group health plan.

Please print.

	Name	Social Security number	Age	Height	Weight
Employee					
Dependent					
Dependent					
Dependent					

A. Please answer yes or no to each of the following questions for yourself and each of your dependents. (If you answer yes to any of the questions below, please explain referencing the Q# in Section B.)

		Yes	No
1	Been admitted to a hospital or had surgery in the past five (5) years? If yes, explain in Section B.	☐	☐
2	Within the past two years, have you, or has any dependent you are enrolling, been disabled and/or incurred medical costs exceeding $5,000.00? If yes, explain in Section B.	☐	☐
3	Been told that it may be necessary for you to be admitted to the hospital or have surgery in the future? If yes, explain in Section B.	☐	☐
Been diagnosed with, treated for, or had treatment for any of the following (if yes, explain in Section B):			
4	Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever, or heart murmur?	☐	☐
5	Hypertension?	☐	☐
6	Cancer, tumor or other malignancy?	☐	☐
7	Diseases of the kidney, liver, gall bladder, pancreas or male/female organs including venereal disease?	☐	☐
8	Arthritis, back pain, rheumatic fever, or musculoskeletal/joint problems?	☐	☐
9	AIDS, AIDS-related complex, or other immune-deficiency disorders (except HIV infection), infections, or chronic infection problems?	☐	☐
10	Alcohol or substance abuse, mental/nervous disorders?	☐	☐
11	Ulcer, colitis, difficulty swallowing, stomach problems, hernia, or rectal problems?	☐	☐
12	Diabetes, cystic fibrosis albumin or sugar in the urine, or other endocrine problems?	☐	☐
13	Asthma, emphysema, tuberculosis, pleurisy, or other diseases of the lungs?	☐	☐
14	Paralysis, epilepsy, multiple sclerosis, or other neuromuscular disorder?	☐	☐
15	Bleeding or blood disorders (except for HIV infection)?	☐	☐
Other conditions/information			
16	Are you or any dependents now pregnant or expecting a child with anyone whether listed on this application or not? If yes, due date: _____/_____/__________	☐	☐
17	Any other medical condition that has not been disclosed above? If so, describe in detail in Section B.	☐	☐
18	Have you or any of your dependents used tobacco products in the last two years?	☐	☐
19	Are you or any of your dependents taking any medication (except contraceptives) that require a prescription by a physician?	☐	☐
20	Have you or your dependents gained or lost more than 20 pounds in the last year? If yes, list amount: ☐ Gained __________ ☐ Lost __________	☐	☐

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An Independent Member of the Blue Shield Association

blue of california

Health Statement *(continued)*

(Please print)

Employee name **Social Security #**

No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits a HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.

B. Complete the following for any "yes" responses from questions 1 to 20 (please indicate the question number below):

Q.#	Dependent (or self) name	Name and address of physician or clinic	Date treat-ment began and ended	Name of condition(s) illness(es) treated	Indicate treatment rendered and current status (recovered, still in treat-ment?) Include name of medication (if taken) and dates prescribed

Attach additional sheets if necessary.

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this Employee Application, including this Health Statement, is a part of my and my dependents' application to be added to my employer's Blue Shield of California health plan contract or Blue Shield Life Policy.
I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded.

Signature of employee **X**________________________________ Date ____________